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Category:Windows freeware Category:Windows-only software hand and transported to the local hospital for treatment and observation. A resident traveling on call was admitted to a local hospital for a routine outpatient evaluation after being exposed to a small amount of blood while cleaning a medical equipment room. The exposure appeared to be minimal as the blood was removed from the patient's scrub top with a sponge and rinsed into a bowl. The health care worker has not reported any signs or symptoms associated with infection. The contaminated tissues

were sent to the CDC for evaluation and the health care worker was treated and discharged with no sequelae. The origin of the blood exposure was determined to be due to patient blood contamination of an area of the perioperative rooms used for patient monitoring, including alarms. The area of blood contamination was determined to be between the patient's bed and the patient control panel. Evaluation to determine the source of the blood contamination was performed by a request to the hospital cleaning contractor. Disinfection of the equipment room was performed

with a chemical solution, which appeared to be effective in removing the blood, and the equipment room was re-opened. Genital herpetic lesions were identified among prison inmates during routine health examinations. The inmates, who had sexual contact with new inmates, were referred for additional medical examinations. Health care workers showed no signs or symptoms associated with infection and all inmates were treated with oral acyclovir. The duration of the outbreak was less than 72 h. The outbreak was determined to be a result

of a local intravenous drug user (IVDU) who was infected with herpes simplex virus (HSV) type 2. HSV type 2 can be transmitted sexually and hematogenously. The health care worker had mild transient chills and malaise during the primary outbreak in a custodial area; but had no other signs or symptoms associated with HSV infection. Contact with the affected inmate appeared to be the mode of transmission. The suspected syringes were traced and no suspected syringes were found. Hepatitis A is a highly contagious infection caused by the hepatitis A virus, which is highly

transmissible by contact with infected food or drink. The infection is usually transmitted by the fecal-oral route. An outbreak of hepatitis A occurred in an assisted living facility during the winter of 2013--2014 that resulted in two deaths and three cases of hepatitis A. The facility was a mix of assisted living and memory care units. Two community health care workers working in 1cb139a0ed

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